## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2014 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFIC REGULATOR)  {K 000} INITIAL COMME  A Post Survey R	PRY STATEMENT OF DEFICIENCIES	B. WING _	STREET ADDRESS, CITY, STATE, ZII		R
(X4) ID SUMMA PREFIX (EACH DEFIX REGULATOR)  {K 000} INITIAL COMME  A Post Survey R	PRY STATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIF		4/11/2014
(X4) ID SUMMA PREFIX (EACH DEFIC REGULATOR  {K 000} INITIAL COMME  A Post Survey R	RY STATEMENT OF DEFICIENCIES			P CODE	7711/2014
(X4) ID SUMMA PREFIX (EACH DEFIC REGULATOR  {K 000} INITIAL COMME  A Post Survey R	RY STATEMENT OF DEFICIENCIES		8549 S MADISON AVE		
PREFIX (EACH DEFIC REGULATOR)  {K 000} INITIAL COMME  A Post Survey R			INDIANAPOLIS, IN 46227		
A Post Survey R	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
I -	ENTS	{K 00	00}		
conducted on 02 Indiana State De accordance with  Survey Date: 04  Facility Number: Provider Number AIM Number: 10  Surveyor: Mark Specialist  At this PSR surv was found in con Participation in N Subpart 483.70(a 2000 edition of th Association (NFF and 410 IAC 16.a surveyed with Ch Occupancies.  This one story fa Type V (000) cor The facility has a detection in the of the corridor. The hard wired to the resident sleeping	000151 r: 155247 00284060  Caraher, Life Safety Code  ey, Manorcare Health Services inpliance with Requirements for Medicare/Medicaid, 42 CFR a), Life Safety from Fire and the ne National Fire Protection PA) 101, Life Safety Code (LSC) 2. The original building was hapter 19, Existing Health Care  acility was determined to be of instruction and fully sprinklered. It is a fire alarm system with smoke corridors and in all areas open to the facility has smoke detectors to building electrical system in to grooms 166 through 178, 180				
detectors in all of The facility has a	s battery operated smoke ther resident sleeping rooms. a capacity of 140 and had a the time of this visit.				(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01, 02</b>		(X3) DATE SURVEY COMPLETED	
		155247	B. WING _			R <b>04/11/2014</b>	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP C 8549 S MADISON AVE INDIANAPOLIS, IN 46227	CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{K 000}	were sprinklered. The wooden storage shed sprinklered.	ents have customary access e facility has two detached	{K 00	00}			
{K 000}	Code Specialist-Medi INITIAL COMMENTS A Post Survey Revisi Code Recertification a	t (PSR) to the Life Safety and State Licensure Survey 4 was conducted by the nent of Health in	{K 00	00}			
	was found in complian Participation in Medic Subpart 483.70(a), Lit 2000 edition of the Na Association (NFPA) and 410 IAC 16.2. The surveyed with Chapter Occupancies.  The 2007 addition to determined to be of Tifully sprinklered. The	151 5247 1060 her, Life Safety Code lanorcare Health Services nce with Requirements for are/Medicaid, 42 CFR fe Safety from Fire and the ational Fire Protection 101, Life Safety Code (LSC)					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION  NG 01, 02		(X3) DATE SURVEY COMPLETED	
		155247	B. WING _			R <b>04/11/2014</b>	
NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE  8549 S MADISON AVE  INDIANAPOLIS, IN 46227		E I	04/11/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
{K 000}	in areas open to the common to	corridors. The facility has I wired to the building esident sleeping rooms 166 has battery operated I other resident sleeping as a capacity of 140 and had e time of this visit.  ents have customary access e facility has two detached	{K 0	00}			